#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2017

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLÈTED

B. WNG 445409

04/19/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 2030 25TH AVE N

NASHVILI	LE METRO CARE AND REHABILITATION CENTER		NASHVILLE, TN 37208			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
, K 000	Stories: 2 with partial basement Construction Type: II (000) per construction drawings Constructed: 1965 Sprinkled: Yes Census: 71 Certified beds: 111  A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 4/19/2017 following a survey by the Middle Tennessee Regional Office of Health Care Facilities state survey agency on 3/27/2017. At this Comparative Federal Monitoring Survey, Nashville Metro Care and Rehabilitation Center was found not in substantial compliance with the requirements for participation in	ed	a. By 05/07/2017 the Environmental			
K 321	Medicare/Medicaid at 42 CFR Subpart 43 483.70(a) and 483.70(b), Life Safety from Fire, and the related National Fire Protection Association (NFPA) publications, the 2012 edition of NFPA 101 Life Safety Code and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3 and TIA 12-4 and the 2012 edition of NFPA 99 Health Care Facilities Code and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6. NFPA 101 Hazardous Areas - Enclosure	K	Supervisor will install door hardware so the doors to the Housekeeping Storage Room, Central Supply Storage Room, and the Maintenance Repair shop are self-closing or close automatically to meet set standards.  The Administrator will verify the repairs by 05/20/2017.			
SS=E	Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system		=E BE AFFECTED:  a. All residents and all staff and visitors have the potential to be affected but none were.			

AGORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days illowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	: 04/24/2017 APPROVED : 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;				ONSTRUCTION  MAIN BUILDING 01	(X3) DATE: COMPI	
		445409		B. WING			04/	19/2017
NAME OF P	ROVIDER OR SUPPLIER				STR	REET ADDRESS, CITY, STATE, ZIP CODE		
NASHVILI	LE METRO CARE AND RI	EHABILITATION CENTER				0 25TH AVE N SHVILLE, TN 37208		
			-			PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
			7			2 15 15 15		-
K 321	Continued From page	: 1	- 1	K 32	21 C	Continued From page 1	- 1	
		eas shall be separated from		SS=I	=E   <sub>E</sub>	By 05/20/2017 the Environmental Supe	rvisor	
	other spaces by smok	e resisting partitions and				vill inspect doors to all hazardous area		4
		vith 8.4. Doors shall be				out the facility to ensure they self-close		
	self-closing or automa	tic-closing and permitted to	- 1			automatically and found no other negat		
	have nonrated or field	-applied protective plates			- 1	indings.		
	that do not exceed 48 the door.	inches from the bottom of			- ["	manys.		
1	Describe the floor and	I zone locations of			3	. MEASURES TO PREVENT		05/21/2017
		are deficient in REMARKS.			1 -	REOCCURRENCE:		30,2112711
	19.3.2.1					- 1 1 0 tanddan	innee	
					a			
	Area	Automatic Sprinkler				vill inspect doors to all hazardous areas		3
	Separation N/A					hroughout the facility monthly to insure		
	a. Boiler and Fuel-Fire		1		- 1	elf-close or close automatically as a pa	- 1	
	b. Laundries (larger th					acility's Monthly Preventive Maintenan		
	c. Repair, Maintenand					Program and document those inspection		
	e, Trash Collection Ro	s (exceeding 64 gallons)			a	s appropriate. If any issues are disco	vered,	
	(exceeding 64 gallons				ti	hey will be addressed and resolved im	mediately	4
	f. Combustible Storag				Τ	he Environmental Supervisor/designe	e will	
	(over 50 square feet)	•	- 1		re	eview with the Administrator the inspec	ction	
	g. Laboratories (if clas	ssified as Severe			lre	esults.		
	Hazard - see K322)		-		1.			
	This STANDARD is n	ot met as evidenced by:	: ]		þ			
	Based on observation	and staff interview, the	- 1		- 1	dherence to the Preventative Mainten	ance	
	requirements of:	t hazardous areas per the	- 1			chedule and validate the Preventative		
	requirements of.		- 1		N	Naintenance documentation is in place	•	
	2012 NFPA 101 Section	on 19.3.2.1.3	- 12					
	2012111111101000		- 1		4	. MONITORING CORRECTIVE	ACTION	05/21/2017
	The deficiency affecte	d three rooms in the			a	er e e et e e e e e e e e e e e e e e e	resented	
	basement.			1		y the Environmental Supervisor/design		
				k		dministrator weekly and at the monthly		
	Findings include:			()		ssurance/Performance Improvement		
	6 1116/20181 C :	E In 0.45 III -	16	0	- 1			3.00
	doors to the housekee	5 p.m. to 2:45 p.m., the eping storage room, central /		65.54 	ľ	neeting.		

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shop were not self-closing or automatic closing.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: IND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 445409 B. WING 04/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2030 25TH AVE N NASHVILLE METRO CARE AND REHABILITATION CENTER NASHVILLE, TN 37208 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 321 Continued From page 2 K 321 Continued From page 2 SS=E The Maintenance Director was present when the Inspection results and system components will 05/21/2017 deficiencies were identified be reviewed by the QA/PI Committee with NFPA 101 Corridors - Areas Open to Corridor K 361 subsequent plans of correction developed and SS=D implemented as deemed necessary to insure Corridors - Areas Open to Corridor compliance is maintained. Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting This plan of correction constitutes our credible areas, nurse's stations, gift shops, and cooking allegation of compliance with all regulatory facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. requirements. 18.3.6.1, 19.3.6.1 Our date of compliance is 05/20/2017. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to separate areas from the corridor K 361 CORRECTIVE ACTIONS TAKEN: 05/21/2017 per the requirements of: SS=D By 05/20/2017 a licensed fire sprinkler contractor installed a smoke detector in the 1st 2012 NFPA 101 Section 19.3.6.1 (1) or (7) Floor Copy Room to protect the room to meet On 4/19/2017 at 12:30p.m., the door was set standards. The Administrator will verify the removed from the 1st floor copy room. An repairs by 05/20/2017. electronically supervised automatic smoke detection system was not installed in the copy room and the room was not located to allow direct ALL OTHERS WITH POTENTIAL TO 05/21/2017 supervision from a nurse station. BE AFFECTED: The Maintenance Director was present when the All residents and all staff and visitors deficiency was identified. have the potential to be affected but none were. NFPA 101 Corridor - Doors K 363 By 05/20/2017 the Environmental Supervisor SS=D checked all other areas open to the corridors Corridor - Doors throughout the facility and found no other 2012 EXISTING Doors protecting corridor openings in other than negative findings. required enclosures of vertical openings, exits, or MEASURES TO PREVENT 05/21/2017 hazardous areas shall be substantial doors, such as those constructed of 1-3/4 Inch solld-bonded REOCCURRENCE:

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core wood, or capable of resisting fire for at least

20 minutes. Doors in fully sprinklered smoke

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Environmental Supervisor/designee will

check all areas open to the corridors throughout

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Findings include:

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barriers.

2011 NFPA 70 Article 300-21, 760-3(a)

The deficiency affected one of two smoke

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and resolved immediately. The Environmental

Supervisor/designee will review with the

Administrator the inspection results.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

445409

B. WNG

04/19/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2030 25TH AVE N

IASHVILI	LE METRO CARE AND REHABILITATION CENTER	NASHVILLE, TN 37208			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLETION  DATE		
K 372	Continued From page 5  Findings include:  On 4/19/2017 at 1:00 p.m., the 1st floor smoke barrier wall was penetrated by a metal sleeve containing two red wires, the interior of the sleeve was not fire stopped.  The Maintenance Director was present when the deficiency was identified.	K 36 SS=	Ischedule and validate the Freventative		
	S	K 33 SS=	1. CORRECTIVE ACTIONS TAKEN: 05/21/2017 a. On 04/21/2017 the Environmental Supervisor used a fire-rated material to seal the penetration in the interior of the metal sleeve containing two (2) red wires in the 1st floor smoke barrier wall to meet set standards.  The Administrator will verify the repairs by 05/20/2017.		

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EMENT OF DEFICIENCIES    Action	(X3) DATE SURVEY COMPLETED 04/19/2017		(XS) COMPLETION DATE		05/21/2017 pect	8 65/21/2017 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	05/21/2017	API ed. ice 17.	fficient protection to the is provided. For nursing of correction is requisite to
ATEMENT OF DEFICIENCIES  NND PLAN OF CORRECTION  STREET ADDRESS, CITY, STATE, ZI  METRO CARE AND REHABILITATION CENTER   2030 25th Avenue, North, Nash  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATE ZI  REGULATORY OR LSC IDENTIFYING INFORMATION)  A All resis at a larger and a control of throughout throughou	-11	, CODE ville, TN 37208	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	From page 6	HERS WITH POTENTIAL TO BE AFFECTED: Jents and all staff and visitors have the potential to be afferere. By 05/20/2017 the Environmental Supervisor will insparriers throughout the facility for penetrations and found ritive findings.	RES TO PREVENT REOCCURRENCE: nmental Supervisor/designee will inspect all smoke barriers the facility monthly for penetrations as a part of the facility eventive Maintenance Program and document those inspe appropriate. If any issues are discovered, they will be and resolved immediately. The Ervironmental /designee will review with the Administrator the inspection	Iministrator will monitor adherence to the Preventalive ce schedule and validate the Preventative Maintenance alton is in place.	DRING CORRECTIVE ACTION: spection results will be presented by the Environmental //designee to the Administrator weekly and at the monthly surance/Performance Improvement (QA/PI) meeting. results and system components will be reviewed by the Q with subsequent plans of correction developed and ed as deemed necessary to insure compliance is maintain of correction constitutes our credible allegation of complian julatory requirements. Our date of compliance is 05/20/20.	ecting providing it is determined that other safeguards provide suit following the date of survey whether or not a plan of correction svailable to the facility. If deficiencies are cited, an approved plan of
METRO CARE AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  HEROULATORY OR LSC IDENTIFYING INFORMATION)  And A	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	ADDRESS, CITY, STATE, ZIP			O D B O	3. MEASUF a. Environ throughout Monthly Presults as a addressed Supervisor/ results.	b. The Ad Maintenan documenta	4. MONITC a. The ins Supervisor. Quality Ass Inspection Committee implement This plan o	thon may be excused from corre d above are disclosable 90 days te these documents are made a
	DEFICIENCIES CORRECTION	NAME OF FACILITY  NASHVILLE METRO CARE AND REHABILITATION CENTER 2030 251	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				JU	IN -8 2017	statement ending with an asterisk (*) denotes a deficiency which the institut everse for further instructions.) Except for nursing homes, the findings stated are findings stated as findings stated as findings and plans of carriection are disclosable 14 days following the data

If continuation sheet Page \_\_\_

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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